INTERVIEW II

DATE: March 21, 1990

INTERVIEWEE: LEO GEHRIG

INTERVIEWER: Michael L. Gillette

PLACE: Dr. Gehrig's office, Washington, D. C.

Tape 1 of 1, Side 1

G: Do you want to begin with a discussion of your association with the Peace Corps?

LG: Yes. Being a career officer in the Public Health Service and assigned in Washington, I was available when Sarg [Sargent] Shriver talked with Surgeon General [Luther L.] Terry at that time and requested that he send a man over to assist the Peace Corps in the planning of a medical program which would encompass both the care and assistance to Peace Corps volunteers serving in underdeveloped parts of the world, as well as programming in the health area as it would be carried out by volunteers. I had that job to plan and was--

(Interruption)

LG: And after about one month of planning in these very early days of the Peace Corps, we were already bringing aboard the first volunteers and I found myself in the midst of more than planning but operations. As a result, Sarg Shriver asked the Surgeon General to assign me on a full-time basis for permanent duty station there, and I did serve in that capacity for the first two years of the Peace Corps.

During that time then-Vice President Johnson was--and I'm not sure of the exact title--chairperson for the advisory committee for the Peace Corps. While I did not have direct involvement with him, I know that he

had expressed [interest] and was involved to a significant degree in this period of time in the beginning activities of the Peace Corps. Again, I don't have direct experience, but I'm sure that he was very important in guiding through Congress the issues of not only the enabling legislation, but significantly the appropriations, which were funded very well for a beginning organization, as I viewed it, having been in government for some time in the health area and concerned about appropriations for a variety of items.

I'm trying to think of anything else that would have applicability there.

G: Last time I believe you talked, perhaps after we finished the recording, about the question of birth control in the Peace Corps.

LG: Yes, there was an incident. In the pre-planning area the question came up significantly, "What can one do to avoid problems that might be raised by illegitimate pregnancy?" I had to confess that my posture in that area was rather rigid because of my own religious persuasion, [but] I felt it important that we ensure that anyone who was not adequately informed with regard to the basic facts of life. But as you might contemplate, I did not suggest that I would strongly recommend certain prophylactic measures. And this was a matter of continuing concern to the leadership as well as to me.

In any event, two things occurred. There was a decision made for a policy statement, and I must confess at this moment I can't remember what the policy statement really covered or detailed. But I, after considerable argument and personal problem, confessed that I could not be the editor of the policy statement which I believe they felt

necessary. As he was always so capable, I believe that Bill Moyers provided the sort of policy statement that was necessary and that was the end of it.

I must confess, on the other hand, while there was great concern with regard to this area--again, without regard to country or names--and we were so sensitive to anything that happened in the Peace Corps in the early days because of the comments of a variety of well-meaning people with regard to the concerns for the health of our young people who were going there, who were very exceedingly promising people, we consequently were very sensitive. For example, early in the Peace Corps experience we had the first two deaths, and these two young men were in Columbia, [and it] had nothing to do with physical illness as such. They both happened to have a period of time off in which they had, if you will, liberty, and did decide to take a plane trip to some adjacent area and the plane unfortunately crashed into a mountain. Because of the concerns, as an example, the director of training [director of selection?] then, Mr. [E. Lowell] Kelly and I each split up and went to the homes of the families to inform them, because after the accident occurred it was suggested the plane had crashed, but it was a matter of days before it was discovered and the results of the crash could be transmitted to the families. This was very much the sort of sensitivity that Sarg Shriver had.

Each of the families had us on the their doorstep for a period of about the best part of a week while we waited for the search to be done, in an effort to be of any assistance we could be to them and also to transmit rather rapidly anything that we learned.

G: So you were the bearer of news--?

LG: We were the bearers of the bad news. I would say I never saw anything like it. Obviously both of the boys that were killed were promising young people. Our selection and opportunities were for the best of what I thought was dedication in an individual was occurring [sic], and both of these boys had very promising sorts of futures, having finished their education and gone into the Peace Corps immediately. But the families, while having all the sorrow that one would anticipate were also about as understanding as I could imagine anyone could have been, and very supportive of the Peace Corps effort both before and after this incident.

A well-meaning Peace Corps volunteer became very well known in the American papers of those days because she wrote a postcard to a friend in the United States. And on the postcard she wrote some rather sharp criticism of what she was experiencing in the African country in which she was a volunter. Unfortunately, the card was read by local nationals and it became a very delicate international incident.

Well, you can imagine with this sort of a background the concerns that were felt when we got word from a doctor in Africa that one of the unmarried Peace Corps women was in fact pregnant. The best knowledge was that the father of her child was from West Africa. We were very concerned. There was uconsiderable consternation by some.

G: By some, you mean people in the administration?

LG: Yes. People in our offices, if you will, of the Peace Corps, as to how to handle this sort of a problem. Like so many things in life, when we finally got all of the information, the problem was not a problem. This

couple were very much in love and they were married and they did return to the United State ultimately with their child. So that many of the thoughts and concerns about this, particularly since we were dealing in an area both internationally having certain nuances, but also very importantly a high-attention program, at least of that administration, but it, as I say, went by the board.

At any rate, I guess why I bring it up--and I wish I knew more of the President's immediate involvement in this area--but I had a period of my life, of two years, that I have looked back upon as some of the most rewarding time that I've spent, and one of the times in life where it seemed everything you touched had enthusiasm, and the quality of the people, and the volunteers were absolutely fabulous. And I came to this only through experience, because I didn't go to the Peace Corps as a starry-eyed volunteer. I went there as a rather questioning sort of a person and I was most impressed.

G: I want to ask you to look over this list of the occasions on which you went to the White House and see if any of those trigger specific memories that are worth recounting.

LG: They missed one, the swearing-in of Sarg.

To me the flight up to Windsor Locks [Conn.] in ***Air Force One*** was memorable for one thing. It was my only experience in that airplane. But the President invited the Secretary of HEW.

G: John Gardner?

LG: John Gardner and myself and Joseph H. Meyers who headed the Medicaid program for the department. [He] invited us into his area of ***Air Force One*** for lunch. I don't recall enough of what really went on except to

sit across the table from the President of the United States, eating a hamburger, was a unique and wonderful experience. He was very much involved--what I think amazed me more than anything, the one thing I recall, the discussion was not on what we were going to be doing at the governor's conference. The President had a whole series of magazines like ***Time***, ***Newsweek***, et cetera and he had a series of articles that he apparently had scanned or had been brought to his attention and he was raising questions one right after the other. The scope of his scanning, if you will, was most impressive to someone who hadn't seen him in action.

I think the other one wasn't at the White House, but I was invited to his signing of the bill on immigration at Bedloe's [Liberty?] Island in New York. It was a beautiful, beautiful show. I must say, while the President from the distance that I saw him did his usual excellent job, quite aside, one of the most impressive ceremonies of a politician occurred for me on that trip because--the boat going to Bedloe's Island departed from South Ferry in Lower Manhattan. Obviously there were many, many very prominent people that were getting on that ferry to go over, one of whom was an ambitious politician by the name of Nelson Rockefeller. But what amazed me was Mr. Rockefeller shook hands with everybody from one end of the ferry wharf to the other, very personably, and then got on the ferry. But I never saw one who worked a crowd any more energetically than he did.

Most of the other thoughts here--a couple of these pieces of legislation were close to our heart, like the Allied Health Professions Bill and Comprehensive Health Planning. Those two were ones that we

were terribly interested in, although probably not very important on the national scene.

G: I may have asked you last time about the VA hospital closings and I know that went through VA, but did you have any involvement in that at all?

LG: No, not directly. We were more concerned because we had threats of closures of the U.S. Pubic Health Service hospitals at that time. It since of course has occurred. At that time we had a little opportunity to expand our research area, but we were really working hard on that one to try to maintain it as a source of manpower recruitment.

G: How about the Partnership for Health program? I guess it was formally the Comprehensive--

LG: The Comprehensive Health Planning Act, yes. We were really living in a period where health planning was a high priority item. The usual concerns of appropriating bodies were being expressed because of the duplication of health facilities, particularly where there were high capital costs, et cetera. I must say, and I testified this way, I felt personally very strongly that it was an important element. If we could have comprehensive planning which provided the level of coverage that was necessary for an area, but did not provide the opportunity for expensive duplication, we were in good shape.

I can't vouch for how effective [it was] except that the program was abandoned ultimately--it seems to me that the problem [was one] of politicization of planning.

I still think, and it seems to me even though the act was ultimately done away with, something of that nature is so vital and we see it more and more now in terms of health care costs. I think hospitals

generally have--you can't say you heartily support something; everybody wants to be the first guy with the most. But the truth is that it seems to me that there was more support in general areas to try to come to some agreement that there would be a sharing of services and that sort of thing. It's one of those things I've always felt that if it doesn't exist someone is going to reinvent it again.

G: Has there been much progress in that direction since the 1960s?

LG: Yes. I suspect it reached a peak--and I'm not sure of my timing, but I guess it would be in the latter half of the seventies. In other words, the program progressed quite a ways and for quite a while. It also became more snarled, if you will, in politics as it matured in terms of its existence. I don't recall the exact time when the act was abolished but it seems to me that it was in the early eighties that it was finally done away with. I think it was because of a lot of frustration and some ineffective management of the thing too.

G: The House of Representatives in 1967 added a rat control amendment, which had been defeated earlier, to this bill. Do you recall that?

LG: I remember the rat incident. I don't know enough of the ramifications. What comes to my mind right away was there are occasions where something becomes a convenient vehicle for what is otherwise somebody's idea. I guess we've all come to learn that man may be smart but he's not smarter than a rat. The ability to get that critter out of the way really has not been reached yet. In some of the worst of the stories that you heard, particularly from depressed areas; children being bitten by rats in the crib and all that sort of thing--as I recall, it seems to me like they put something like nine million dollars or something into the first

appropriation. It was a significant dollar sum. I don't really recall who was really backing it, but my memory would say it came out of the New York area. But it did get support and if I recall correctly CDC [Center for Disease Control] had an important role to play in the implementation of it, but that's about where I lost it.

G: The National Eye Institute created an independent eye institute at NIH to consolidate the existing programs. This was also in 1968.

LG: I don't know. I don't remember that one. It was at that time that I went over to head the Office of International Health. I don't believe I had a thing to do with that.

This other thing, you know, on planning, if I can add one more deal because in the decade of the eighties--at least I felt--we saw reasons why we needed it. There are three additions to medical technology that have been very significant. One is lithotripsy. I don't know if you're familiar with it but this is the capability, without invading the body, of breaking up a renal stone by sound waves. You immerse the individual in a bath; you have a source of sound waves in the tub. You can aim it by fluoroscopic controls so that it's right on the stones and the kidney pelvis and you can break them up.

The second one is magnetic resonance imaging. I don't know whether you've heard of it. With all the fears we've had with x-ray--and well-founded--because while it's marvelous to locate something in the body it has limitations in terms of being able to differentiate things, but it also has a bad side effect in that you don't want to expose anybody to much of it. This new magnetic resonance imaging does not depend on x-ray and it's used now in scanners. It not only can look

at soft tissues like the brain, but it shows a variation in the picture it presents to the computer, which is biologically determined. In other words, a diseased condition and its functioning within an organ can be differentiated. For the first time you see something where you take a picture that comes out as an image, and it may show a change because that tissue is suffering from a certain type of disease. Fantastic.

The third one besides this--I'm losing the third. This is enough to make my point. There's a third and I'll think of it, but each of these costs several millions of dollars to install in an institution. The need is fabulous where you need it, but the need isn't in every facility and yet every facility wants it, because if you're going to get good doctors on your staff they want to have that right there. They don't want to have it across town or someplace else. And this is where cooperative planning and development of something like that--there even can be a sharing of costs--even though you get in this community of X size, [and] all that is needed to cover everybody's need is one, and you decide where it's going to be placed. Three or four or five different facilities may share in its cost and then they share in its use. This is what we envisioned originally being the big value of having a planning act. And you needed some teeth in it in order to get a decision forced because otherwise if you get two hospitals with enough funds they can both buy one.

G: Well, what were the teeth?

LG: Well, the teeth in the Comprehensive Planning Act was the certificate of need. In other words, in order to get something you must have a certificate of need. You don't get a certificate of need unless the

planning body looks at the needs of the area and decides based on that, that yes, you ought to have it. Now if they say no, the other hospitals are going to get one and we'll all share it. You can say, "Well, I'm not going to get in the act," and then you're just left out. But this provided very important teeth. It's very much like getting an authority to build a home when you're needing a zoning exception.

The fact is that we now moved into areas where the cost is so big for the initial investment, and it only can be reflected in bills later, that the planning act becomes very important. It's just like building a new hospital. Why build one? Because somebody wants one in their place or whether it's needed? If it can't be built, then it's not going to cost anything. But if it is built, no matter what else happens, those costs are going to be spread out over the bills for health care in that community.

G: Anything else on the failure of Congress to pass the legislation that would have modernized urban hospitals; the tendency to keep the Hill-Burton Act orientation rural?

LG: Well, I don't think--while Hill-Burton was initially developed and did give a degree of priority to rural, this is not to imply that it wasn't used many, many times in urban areas. So I don't see the problem of its continuation being because of it favoring the rural hospitals, so much as this government over a period of thirty years, almost, invested many, many millions in the improvement of all hospitals. This program was viewed by many as seed money to initiate institutions where they were needed. We then moved into a period where institutions were assisted in many of the areas that needed them. It then became very important

because significant amounts of money in the later years was for modernization. But Congress finally decided we had gone about as far as we could go.

There was an aspect with the Hill-Burton Act which has been felt very keenly by facilities in the last twenty years. Hill-Burton had kind of a sleeper component that when you got that money, you agreed to provide care whether or not a patient could afford it. Well, it wasn't unusual for hospitals because that's been a pattern over the years. Well, as time went on government began to be looked at critically, as how much voluntary work have you done; what volume of business did you give away? There was a ratio established of the amount of money in your grant, and how much you should contribute as "free care" each year. It was rather significant. Over time it necessitated paying the grant back not once but quite a number of times.

G: It was a percentage?

LG: Yes. I've forgotten now the details of it but it was worked out that way, and there were reviews of this to be sure that hospitals were doing their share. That in itself became an issue, but another issue came that the government began to say, "We used to pay your rate"--whatever it was--"but we're not going to pay it anymore," or, "We're going to agree on a rate that has a little different component." In other words, it wasn't cost-plus financing. Well, it's the old story: there is no "free lunch." The costs of "free care" have to go someplace. The government cut back on its payments in Medicare and Medicaid and hospitals had to depend then on other third-party payers for this shortfall. So individuals and private insurance paid more.

Well, now we've evolved into the period where we have DRGs [Diagnosis Related Groups]. I don't know whether you're familiar with that term, but now a hospital gets paid for a service based on a statistical average stay of a patient for a particular complaint, with a little adjustment vis-a-vis complications and so on. So now they're not looking at how much did you spend on this patient, but statistically we'll give you this much and you treat them. It's like a contract. You may guess right or if you discharge patients earlier it's going to make you a little money. If you don't get them out that quick you're going to lose. Well, the approach isn't bad. On the other hand, it doesn't look into other things. For example, there are lost causes in training. A good first-class hospital is going to have a large training program; it has residents and interns in a variety of areas, including medicine. That doesn't come for nothing. There are costs to training.

There are costs, for example, if I run a first-class hospital and and maintain an emergency room. Keeping that open twenty-four hours a day must be amortized over the services provided. Many of what you might consider, in a crass business way, lost leaders don't get covered. Well, you get all of these factors: government limitations on programs; other third-party payers limiting reimbursement; a hospital with big training programs, operating an emergency room and other "lost leaders" and with big capital investments one finds real problems.

Well, what we've seen--going back to the Hill-Burton side of it--is that you can only do as much as you can pay for. The hospital is no different than any other business. There was a day when it was considered eleemosynary in terms of nurses working for very inadequate

salaries; a lot of contributions along the way. Times have changed. Nurses have a union. Nurses get paid and they get paid for what they do, as they should. Everybody else in the hospital is that way, so that till has got to be big enough to pay the bill for what you're doing. When the government says, "Yes, but you have to give X," it's pretty tough. And they've been doing it.

This sort of thing--actually as I saw a change in the seventies, I think hospitals who then began to be knowledgeable about private financing didn't look nearly as favorably on Hill-Burton. Number one, the amount of money was small. There was still a rather significant number of hurdles as you would have in any grant activity. You wind up with further obligation with regard to what you must do. Generally, hospitals want to treat whoever comes in the door. But there is an absolute necessity in this day that the director of a hospital has to also make sure that he can pay everybody that he owes. So Hill-Burton slowly--not too slowly but over a decade--phased out. I think there weren't too many strong complaints because I think people felt the bill did what it's original framers, Hill and Burton, had thought they wanted to do, and then we ran into all of this other sort of background.

G: Any recollections of the National Advisory Commission on Health Facilities which LBJ appointed in 1967 to make recommendations for financing the construction and modernization of hospitals?

LG: No, I don't. You don't have the name of the chairman?

G: No.

LG: I think the one I'm confusing it with--there was also a commission aligned for reorganization of the Public Health Service and I spent

modest time on it. I don't think I have--I know one of the problems at that period of time related more to the public hospitals, because some of our biggest public hospitals were going down the tube. There was considerable concern about being able to modernize them.

So often a study like that becomes tied up with somebody's name as the chairman and that. . . .

G: I don't see it in my notes.

(Interruption)

LG: I think that had to do with the reorganization of the Public Health Service. And that's the team that I do recall and I can't think of the name of the chairman. Yes, this is it. And we had a good deal of time spent on this.

One of the basics here was to, as this points out, reorganize PHS. The biggest single area wasn't in my mind the organizational patterning of existing programs, because generally all of these areas existed before under another name and there was some shifting of programs. But that wasn't so complex. One of the big efforts was a reorganization package for the change in the Public Health Service Commission Corps. In my judgment, one of the biggest issues here was to do away with the commissioned corps and get an alignment for what were then commissioned people under civil service. See, we had already in NIH developed an NIH scheme which was not limited to a commissioned corps. It had a rather advantageous pay pattern too, at the upper grades, [and] didn't have the restrictions that a commissioned corps has.

On the other hand, there were many of us who came up through the commission system as I did through our clinical facilities. I would

have never come into public health service to work in public health; it was not my interest. But I was very interested in coming in to work in chest disease, and with our programs at that time and our hospitals, I spent about half of my career out doing thoracic surgery. I shifted over to administration and enjoyed that too at a later date, but this was true of a lot of physicians that at that time had come in primarily for a clinical role. And a certain percentage of those could be enticed slowly, as they finished their training--because we also got training in the service--to stay on for a career. Losing our hospitals and losing our commissioned corps was going to make it tough.

This is an example of the problem. Before 1955 the Division of Indian Health was staffed by another government department. It was then transferred to the Public Health Service as we had a resource for staffing it. The program operated a large number of small Indian hospitals and clinics. Now, to take a doctor and send him to Kotzebue [Alaska] is tough under the civil service system, generally, because that puts him there and that's it. We had a system where, if a physician served there because he was under orders, there were opportunities to both provide back-up for him in his medical work and to reward him with a different assignment or training after two years.

Tape 1 of 1, Side 2

G: Okay. Why don't you tell me about your work beginning in 1968 with the Office of International Health as director?

LG: Well, briefly, because of my experience with the Peace Corps, this was for me. I had had one other experience with international health, that when I was deputy chief of the Division of Hospitals for the service, I

was on the WHO, World Health Organization, advisory council with regard to health of merchant seamen. We wrote a book on what to do until you can get them to port and that sort of thing. Public Health Service hospitals used to run a service in which we provided assistance to ships at sea around the world from our stations in the United States. For example, the one in Galveston would have had a role, as did New Orleans, through the whole Caribbean area. And by short wave, through RCA usually, the ship's captain or the mate would call in and say, "I have a man and this has happened. What do I do?" And RCA plugs us in--and we had twenty-four hour coverage--and we'd go back telling them what to do.

And under certain circumstances in the emergencies we would ask the Coast Guard to go out and pick him up or take someone out to do something for him. And because of the international role I had in that experience and in the Peace Corps.

Obviously some of our concerns there were financial, because the United States paid such a major portion of the WHO budget. Being on the board of WHO, it was my responsibility to carry out the business of trying to hold costs for the United States down.

During the period I think the most exciting clinical thing that happened was the role that WHO and PHS played as a part of a multilateral effort in the control of smallpox. We had assigned from the Public Health Service and CDC (Communicable Disease Center in Atlanta, Georgia) an officer to WHO to direct smallpox control. Over a course of several years this disease was eradicated. Now you leave this country and you don't worry about getting a smallpox vaccination because the disease has been controlled.

End of Tape 1 of 1 and Interview II

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